Neal Smiles ORTHODONTICS

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name _____ (First / Middle / Last) Age _____ Birth date _____ (MM-DD-YYYY)

Nickname (if preferred) _____ Male Female Email _____ (Will be kept confidential for our use only)

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____ (Street / City / State / Zip)

Social Security # _____ How did you hear about our office _____

General Dentist _____ Last visited _____ Occupation _____

Have we treated another member of your family? YES NO (Circle) If YES, Name _____ (First / Last)

Have you visited an orthodontist before? YES NO (Circle) If YES, for what reason? _____

Is there anything you would like to discuss with the doctor in private? YES NO _____

School _____ Hobbies/Interests _____

Responsible Party/Insurance Information

Primary Circle Self Father Mother Step Parent Spouse Other _____

Marital status: Single Married Widowed Divorced Separated Domestic Partner

Name _____ Email _____ (Will be kept confidential for our use only)

Address if different than child's _____ Birth Date _____

Home Phone _____ Cell Phone _____ Work Phone _____ SS# _____

Employer _____ Insurance Company's Name _____ Group or Plan # _____

Insurance company phone # _____ Insurance company Address _____

Secondary Circle Self Father Mother Step Parent Spouse Other _____

Marital status: Single Married Widowed Divorced Separated Domestic Partner

Name _____ Email _____ (Will be kept confidential for our use only)

Address if different than child's _____ Birth Date _____

Home Phone _____ Cell Phone _____ Work Phone _____ SS# _____

Employer _____ Insurance Company's Name _____ Group or Plan # _____

Insurance company phone # _____ Insurance company Address _____

Other Circle Self Father Mother Step Parent Spouse Other _____

Marital status: Single Married Widowed Divorced Separated Domestic Partner

Name _____ Email _____ (Will be kept confidential for our use only)

Address if different than child's _____ Birth Date _____

Home Phone _____ Cell Phone _____ Work Phone _____ SS# _____

Employer _____ Insurance Company's Name _____ Group or Plan # _____

Insurance company phone # _____ Insurance company Address _____

Dental and Medical History

Is patient in good health? Circle one: YES NO Describe: _____

Is patient taking any medications or other substances? YES NO

Please list medications/substances_____

If female, is patient pregnant or suspect of pregnancy? YES NO N/A _____

Under the care of a physician? YES NO Explain: _____

Physician name and phone number_____

History of major illness? YES NO Describe: _____

Any sensitivities or allergies? YES NO List: _____

Have the adenoids and/or tonsils been removed? YES NO Explain: _____

Pain/tenderness/locking in the Jaw Joint (TMJ/TMD)? YES NO Explain: _____

Injuries to the face/mouth/teeth/chin? YES NO Explain: _____

Main orthodontic concern: _____

Any condition not listed that you would like the doctor to know about: _____

Has the patient had any of the following medical problems? Please **circle** YES or NO

YES NO ADD/ADHD	YES NO Cancer	YES NO Headaches (Severe/Frequent)	YES NO Pneumonia
YES NO AIDS/ARC	YES NO Cold Sores	YES NO Herpes	YES NO Psychiatric Problems
YES NO Anemia	YES NO Diabetes	YES NO Heart Murmur	YES NO Radiation
YES NO Angina	YES NO Dizzy Spells	YES NO Heart Condition	YES NO Rheumatic/Scarlet Fever
YES NO Arthritis	YES NO Epilepsy	YES NO Kidney Problems	YES NO Tuberculosis
YES NO Asthma	YES NO Fainting	YES NO Liver Problems	YES NO Ulcers/Colitis
YES NO Blood Disorder	YES NO Fever Blisters	YES NO Low Blood Pressure	YES NO Venereal Disease
YES NO Bone Disorder	YES NO GI Disorder	YES NO Nervous Disorder	Other _____

Please Circle YES or NO to the following **habits**:

YES NO Chewing/Eating Problems	YES NO Nail biting	YES NO Teeth Clenching	YES NO Tongue/Thumb/Finger sucking
YES NO Lip biting	YES NO Pen/Pencil Biting	YES NO Teeth Grinding	
YES NO Mouth Breather	YES NO Speech Problems	YES NO Tongue Thrusting	

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my/my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits.

Signature _____ Date _____

Patient/Parent/Guardian Yearly Review

12 Month _____ Initial and Date

24 month _____ Initial and Date

36 month _____ Initial and Date